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Ebola Community Action Platform (E-CAP)
Funded by USAID/Office of US Foreign Disaster Assistance
Final Report
September 2014 – July 2015



COUNTRY CONTACT	HEADQUARTERS CONTACT	PROGRAM SUMMARY	
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Context

The Ebola Virus Disease (EVD) hit West Africa in March 2014 and subsequently developed into an epidemic, resulting in 27,952 total cases confirmed with 11,284 dead in the West African region by mid-August 2015. The epidemic has hit Liberia the hardest, with 10,672 cases and 4,808 deaths. In neighboring Sierra Leone and Guinea, there were 13,494 and 3,786 cases, resulting in 3,952 and 2,524 deaths, respectively.¹ Currently, there are no EVD cases in Sierra Leone but new cases in Guinea continue, but seem to be tapering off. The case and death counts worldwide, ranging from Nigeria to the United States, are 27,988 and 11,299, respectively.

The epidemic was a full-scale emergency, with national, regional and global impacts. The response engaged leading specialist agencies such as the Centers for Disease Control (CDC) and the World Health Organization (WHO), working in partnership with national governments, donors, United Nations (UN) agencies and international and local non-governmental organizations (NGOs). In Liberia, the response was led and coordinated through the Incidence Management System (IMS), co-chaired by the Ministry of Health (MoH) with lead partner agencies. The response incorporated both direct provision of health services and social mobilization to engage communities in preventing the transmission of EVD.

While the country seems to be returning to normality, there is concern about complacency setting in and vigilance declining, which could put the country at risk for another outbreak. The MoH is leading the effort for strong and effective messaging about maintaining vigilance and certain hygiene behaviors, such as frequent hand washing and safe handling of dead bodies. And, the MoH community health services division with support from the international community is revamping its policy in preparation for a country-wide roll out of the strengthened community health care system, including better trained health workers and functioning clinics in January 2016.

As of this writing, there has been a successful Ebola vaccine trial in Guinea, resulting in 100% efficacy in individuals. For the 13,000 people who survived EVD, new research shows that many survivors face continuing health problems such as loss of vision, excruciating joint pains, etc. To date, there is limited data on the types and frequency of various survivor health problems and gaps in clinical care. Addressing the gap is a group of international health practitioners, scientists, epidemiologists working on a “Comprehensive Care Plan for EVD Survivors” which includes the needed research to identify and optimize clinical health care and social well-being.

Executive Summary

The Ebola Community Action Platform (ECAP) sought to enhance awareness and uptake of behaviors that reduced Ebola virus disease (EVD) transmission across all 15 counties of Liberia through community-led and national social mobilization activities. The project used a sub-granting methodology to establish partnerships with local and international NGOs. This network of 77 partners reached out to trusted communicators in over 3,000 villages and urban settlements. It provided a channel for the delivery of Ministry of Health-approved Ebola mitigation messages, as well as a platform for investigating and learning from field-level experience of the epidemic.

The 10 month program, which ran from September 2014 to July 2015, met or exceeded program targets. ECAP achieved the following:

- 2.4 million beneficiaries reached, representing 56% of the total population of Liberia,
- 804 mobilizers trained who then trained over 14,719 communicators,
- over 1.5 million community members adopted health practices promoted in ECAP messaging,

¹ Figures from WHO Ebola Situation Reports updated August 19, 2015: <http://apps.who.int/gho/data/node ebola-sitrep>

- the information management system allowed our partners to report on knowledge, attitudes and practices (KAP) regarding over 2 million people, supporting humanitarian coordination and information management,
- all partners had access to the Monitoring, Evaluation and Learning System (MELS) dashboard, which is open access,
- rapid research studies were completed, and
- behavior uptake measurements taken.

Mercy Corps (MC), with complementary training support from technical partner Population Services International (PSI), strengthened the ECAP network. MC's relationship with the network deepened as support was given to help partners identify and overcome challenges. The adaptive management processes employed by the program helped partners respond to changes in the environment. The program design worked: the partners chose where they worked, who to work with and how to deliver messages, and as a group met their program targets.

Key Data Table		
	Target	Achievement by July 12, 2015
<i>No of sub-grant partner proposals received</i>	No target	116
<i>No of lead partners</i>	10-20	26
<i>No of sub partners</i>	No target	51
<i>Proportion of local NGOs (lead and sub) that are Liberian</i>	No target	93%
<i>No of mobilizers enrolled</i>	1,000	804
<i>No of communities targeted</i>	2,500	3,014
<i>No of counties targeted</i>	15 (100%)	15 (100%)
<i>Funds available for sub grants</i>	\$6.5m	\$4,871,285 disbursed

SECTOR #1	Objective: To enhance awareness and uptake of behaviors that reduce EVD transmission through community-led and national social mobilization activities		
Health			
Beneficiaries Targeted	2,000,000		
Beneficiaries Reached	2,441,599 51% male; 49% female		
Geographic Area	Nationwide		
Sub-Sector: Community Health Education/ Behavior Change			
INDICATORS	BASELINE	TARGET	ACHIEVED (07/12/2015)
Number of CHWs [communicators] trained and supported (total and per 10,000 population within project area), by sex	0	15,000	14,719; 44% female; 56% male

Number and percentage of CHWs [communicators] specifically engaged in public health surveillance (not measured as per justification below)	N/A	N/A	N/A
Number and percentage of community members utilizing target health education message practices	No touching: 75% Calling burial team: 87%	1,500,000 community members reached (75%)	95% of 2 million--26% increase 97% of 2 million—12% increase
<u>SECTOR #2</u> Humanitarian Coordination and Information Management	To support stakeholders to effectively contribute to and utilize information management systems which enhance coordination, performance and learning on social mobilization in EVD emergencies		
Beneficiaries Targeted	2,000,000		
Beneficiaries Reached	2,441,599		
Geographic Area (s)	Nationwide (all 15 counties and where E-CAP partners operated, focusing on areas of high caseloads)		
Sub-Sector: Information Management			
INDICATORS	BASELINE	TARGET	ACHIEVED (07/12/2015)
Number and percentage of humanitarian organizations utilizing information management services	0	All partners in ECAP access and utilize online dashboard	Partners trained and have access (77 Partners)
Number and percentage of humanitarian organizations directly contributing to information products (e.g., situation reports, 3W/4W, digital tools)	0	All Partners in ECAP	All implementing partners contributed on a monthly basis; 64,270 KAP surveys and activity reports

Number of products made available by information management services that are accessed by clients	0	Online dashboard	ECAP dashboard updated monthly and could be disaggregated on a county and district level
		Five research studies	Two barrier analyses (seeking treatment, livelihood impact on survivors); a snapshot study on border communities; a photo voice study on survivors and a program assessment

	Male	Female
Number of mobilizers trained, disaggregated by sex.	488 mobilizers (61%)	316 mobilizers (39%)
Number of community outreach volunteers trained, disaggregated by sex	8,243 communicators (56%)	6,476 communicators (44%)

The only targets which varied from what was planned were the number of mobilizers and communicators in the program. The partners were able exceed their targets with fewer mobilizers (804 vs. 1,000) and communicators (14,719 vs. 15,000). Since the scale of the Ebola epidemic was one that no one had dealt with before, it is surprising that this estimate of the program design is the only one that was different from what was anticipated. As it was, it took fewer people to reach more communities and people than was anticipated which was the overall objective of the program.

Sector # 1 Health

Objective: To enhance awareness and uptake of behaviors that reduce EVD transmission through community-led and national social mobilization activities.

Liberia's weak health system and limited emergency response capacity resulted in the EVD case count quickly accelerating. The initial response from the government and international partners focused on the construction of emergency health facilities known as Ebola Treatment Units (ETUs), but the reduction in cases was the result of work done by the people in communities all over Liberia. The ECAP project was designed to focus on communities and civil society as a way to complement the emergency response done through health professionals and facilities.

The World Health Organization states that "health officials and their partners were quick to recognize the importance of community engagement. Health teams understood that community leadership brings with it well-defined social structures, with clear lines of credible authority. Teams worked hard to win support from village chiefs, religious leaders, women's associations, and youth groups."

To meet the complementarity of the emergency response, Mercy Corps developed the sector 1 objective of the ECAP program's core messages centered on reducing EVD transmission through social mobilization. Through social mobilization, basic information about EVD signs, symptoms, spread and transmission, health seeking behaviors, ETUs and stigma was brought to communities using methods and learning techniques tailored to the particularities of each community. It was primarily through local civil society organizations (73 of the 77 implementing partners) that had worked in the country for years and knew communities to deliver information that was readily understandable and actionable.

Supporting these efforts was the mass media arm of the program, managed by IREX. IREX worked with community radio stations throughout the country to help disseminate MoH messages and reinforce awareness and behavior change campaigns.

To assess the results of the achievement of this objective, research was designed as a qualitative assessment of beneficiaries' perception of the ECAP program performance. The results served primarily to improve future performance and validate known successes of the program. The full study is appended to this report, but following is a synopsis of findings and analysis.

The primary tools used in the assessment were key informant interviews, focus group discussions (FGDs) and observations. The interviews and focus group discussions were conducted with individuals within communities, and did not include anyone directly involved in the ECAP program. The FGDs included men and women and had 10-12 participants in each group. To try to gauge the impact of ECAP, Non-ECAP communities were included in the assessment. The tools employed were substantially the same for both ECAP and Non-ECAP communities.

The four focus areas of the study and what was learned:

1. **Knowledge uptake:** Was there knowledge uptake in ECAP communities? If so, on what topics was there greatest knowledge uptake? How did the ECAP methodology contribute to this knowledge uptake?

The assessment found high knowledge levels in ECAP communities on a majority of the Ebola related messaging topics. The knowledge level in ECAP communities was found to be significantly higher than in Non-ECAP communities suggesting that this knowledge uptake is a result of the ECAP program. This knowledge is an expected outcome of the ECAP program. The knowledge areas where the greatest knowledge uptake was found were:

- Ebola prevention methods: not touching sick people, not touching dead bodies, etc.
- Personal hygiene: washing hands, clean environments.
- Signs and symptoms of Ebola
- Ebola transmission methods

The assessment found that community members from ECAP communities could explain the "why" behind the messaging, while those from Non-ECAP communities could not. For example, community members in ECAP communities could explain that they have to wash their hands with soap or chlorine because the virus can live on their skin along with other germs and the soap/chlorine will kill it during the hand washing process. Community members from Non-ECAP communities could not explain why they had to wash their hands or why soap/chlorine is meant to be used.

The assessment found that community members within ECAP communities could identify 'ECAP Communicators' by the methodology they were using, that of sitting, discussing, and answering questions. Participants stated that this approach allowed them to ask lots of questions

and really understand the messages. The most successful way this was done was through the door-to-door methodology used by Partners. As the ECAP communicators were living in communities they were able to respond to questions, even after the original discussion period, as a FGD participant stated “Because the mobilizer was living with us we had more knowledge on Ebola”.

This approach was identified as being different from other groups who gave brief explanations or recounted the Ebola slogans. A community member from an ECAP community compared the ECAP approach to the Ebola loudspeaker announcements another by another NGO and stated “The loudspeaker awareness was mostly done on car with music and was not really clear. We were not able to ask any questions.” Additionally, a community member from a Non-ECAP community stated in regards to the effectiveness of Ebola activities conducted by another NGO in their community “We did not get the message well because the people used to be in rush to go to another community, we were not able to ask question to get clarity on few question.” This highlights the importance of having individuals living within communities conducting the social mobilization as they are able to provide constant follow up information and answer questions that arise after the initial information is disseminated.

2. **Behavior change:** Was there behavior change in ECAP communities? If so, in what areas did this occur? How did the ECAP methodology contribute to this behavior change?

The program assessment found that behavior change did occur in ECAP communities. The key behaviors that were changed were:

- The overcoming of Ebola denial
- Improved handwashing and hygiene practices
- Improved health seeking behavior (where health facilities were available)
- Reduction in stigma towards Ebola survivors.

“It helps us to understand the messaging because they [ECAP Communicator] sit with us to discuss and make us understand that Ebola is real.”
FGD Participant, ECAP Community

This behavior change appeared to stem from the deeper understanding gained in the knowledge uptake process. Community members were linking the new behaviors to positive health outcomes which gave them further encouragement to keep up these behavior practices. In particular, participants were linking their improved hand washing practices to a reduction in sicknesses in their community, particularly a reduction in diarrhea and cholera among children. This motivated community members to continue to engage in these practices beyond the length of the social mobilization program.

The area where the impact of ECAP could most readily be seen was in community member’s behavior towards Ebola survivors in ECAP communities, compared to Non-ECAP communities. As

Listen, Learn, Act

PSI’s adult participatory learning technique, LLA, is a cascade style of training in which PSI trained facilitators (PSI employees) who then trained mobilizers (partner employees) who then trained communicators (contractors). As deployed in the communities, the first thing a communicator would do would be to “listen” to the concerns of the villagers about any topic related to Ebola. Then the communicator would use the feedback in teaching the community about the MoH’s approved messages (“learn”). The “act” part of the methodology was to use the learning and develop action plans to implement activities learned, e.g., hand washing stations for each household.

one FGD participant from an ECAP community stated, “stigma has reduced, we are eating with survivors and playing with them now.”

The assessment found that the behavior change occurred because of three main factors:

1. The individuals passing on the messages were trusted were believed to be presenting truthful information
2. The individuals were persistent with their messaging and ensuring complex details were understood
3. Community members understood the reason behind why they needed to change their behaviors

These factors link directly into the ECAP methodology of using individuals from within communities and using the Listen, Learn, Act (LLA) methodology. Through using community members to do the social mobilization, the ECAP program was able to overcome any potential trust issues that often arose during the Ebola epidemic in Liberia. The ability to receive information from community members, neighbors or friends meant that individuals felt free to trust the information and adopt the behaviors suggested.

3. Community action: Did communities take internal action to protect themselves from EVD? If so, what types of action took place? Can this action be linked to ECAP’s presence in the community?

The ECAP program did not specifically require communities to take community-led action to protect themselves from a further Ebola outbreak.

The assessment found that some ECAP communities, encouraged by some ECAP partners, took action to protect themselves from Ebola. The main actions taken were:

- A taskforce established to monitor the activities and preventative measures taken in the community
- Community leaders enforced a law on hand washing and established hand washing stations in the community
- Community members agree to avoid having strangers visit and register strangers when they enter the community

“Our community leader enforced a law on washing your hands. Community members paid a fine of 500 LD if you didn’t.” FGD Participant, ECAP Community

There was no identifiable difference between ECAP and Non-ECAP communities in terms of the level of community action taken or types of action taken. The effectiveness of these community actions and the means by which they were initiated remained unclear. As a result no clear linkage can be drawn between the community action taken and the ECAP program.

4. Future community concerns: What concerns remain in communities? Does messaging need to be reinforced? If so, in what areas?

Topics needing message reinforcement

Despite the assessment finding high knowledge uptake, there still remains gaps where further message reinforcement is needed. In particular, the topics of stigma to health care workers and survivors and topics on how survivors can spread Ebola need further reinforcement.

Stigma towards Health Care Workers and Ebola Survivors: The majority of participants understood and believed that Ebola survivors could not transmit Ebola, except through sexual intercourse. However, despite this high level of understanding, and the rapid reduction in stigma

levels in communities, there remains a clear gap where further sensitization could occur. Many individuals remain uncomfortable sharing a meal with survivors they had just met, however, would do so after several weeks or months of personal observation of the survivor.

Survivor transmission methods: While basic knowledge levels can be considered significantly high across all communities, participants were still grappling with the concept of how survivors could spread Ebola, particularly in regard to sexual intercourse. Many community members saw this as a reason to doubt the status of survivors and therefore limit interactions with survivors. Until a clear Ministry of Health and Social Welfare direction arises on this issue, community members will continue to be confused and stigma will continue to be a concern.

Community concerns

Communities continue to have concerns regarding their health situation. Community concerns appeared consistent across both ECAP and Non-ECAP communities. The two major concerns that arose during the assessment were concerns regarding the maintenance of Ebola safe practices and access to health care.

Maintenance of good practices: Communities reported many concerns and questions regarding the transition from the Ebola epidemic to the post-crisis stage. They were unclear as to whether they were expected to continue their Ebola prevention practices and what practices they could stop following. They were particularly concerned about culturally sensitive practices which they were keen to recommence, such as traditional burials and personal greetings. Furthermore, communities were concerned about whether the support services surrounding the epidemic would continue to be available. Of particular concern was access to safe burial services and ambulance services. These concerns suggest that further information must be clarified from the national Ministry of Health and Social Welfare and communicated down to the community level.

Access to health services: All health centers have now reopened, but services at most health facilities are still very limited (e.g. only to pregnant women). Health facilities are reportedly treating a very limited number of patients per day; this means that patients coming from far away have to start their journey as early as 5 a.m. in order to reach the health center in time to receive a patient number which entitles them to treatment for that day. If the patient is unable to reach the health clinic by the time number tickets are distributed (which is usually before 7:30 am) they are turned away and have to start the process again the next day. Generally all participants registered no fear of seeking health care at their local health facility and would go there if they or another member of their family fell ill. However, while public health facilities are free there are often times no drugs and patients have to raise the money to purchase prescribed medications which many cannot afford and may have to forgo other family needs to meet the cost.

The success of the approach used by ECAP can be seen in the changing knowledge, attitudes and behaviors shown through ECAP's monitoring data. Following five months of program implementation, the proportion of respondents who stated that they would not touch a sick family member increased by 25%, a critical behavior for disease prevention. The changes in reported behavior are accompanied by large changes in Ebola knowledge, with a 15% change in understanding that Ebola can be spread through sexual intercourse and a 17% change in respondents acknowledging that traditional healers cannot cure Ebola (94% of respondents now state that traditional healers cannot cure Ebola, compared to only 81% in the baseline.) Those results are indicative of the penetration of the health messages.

Monitoring also found a clear trend in reduction of stigma of survivors and health workers, a key theme of the ECAP health messages. The results demonstrated a change from 19% to 75% (Baseline to April KAP)

of respondents reporting that they would be comfortable visiting the house of an Ebola survivor, with a similar change in results for stigma questions concerning Ebola health workers. Such results not only show a strengthened capacity to prevent the return of Ebola, especially along critical border areas, but also indicate an improved likelihood for those touched by EVD to be welcomed back to their homes and regain their livelihoods.

Sector # 2: Humanitarian Coordination and Information Management

Objective: To support stakeholders to effectively contribute to and utilize information management systems that enhance coordination, performance and learning on social mobilization in EVD emergencies.

Online platforms were established to connect partners and share experiences and feedback, including social media channels and WhatsApp. Smart phones donated by the Paul G. Allen Family Foundation were distributed to ECAP partners to support real time information sharing. This information, available to all stakeholders on a public access platform, informed partners and other stakeholders about program issues and results which supported adaptive management and learning.

WhatsApp, ECAP's main digital channel, not only provided information to MC, PSI and the ECAP partners about the achievement of their performance targets but it also provided them with a platform to share experiences and information. In addition, information on the dashboard was also accessed by the public (open access).

Although it was one of the more challenging areas of the program, digital outreach has helped support the wide dissemination of program materials. It has resulted in real time information which has then informed Knowledge, Attitudes and Practices (KAPs) and MELS. The content uploaded on phones has given the opportunity for mobilizers to select appropriate training materials for mobilizers (videos, testimonials, etc.) and information selections for communicators to decide what materials best convey messages to each community. This tool allowed instantaneous flexibility and adaptation at each location. The program's information portal (ecapliberia.org) included program information and many stories. The more traditional communications component of the program was active in publishing stories in many newspapers and radio stations to ensure that program activities were publicized in support of the campaign to stop the transmission of EVD.

While digital and mass media communications were critically important, they did not supplant the face-to-face interactions that were necessary for coordination and relationship building. To this end, MC and PSI were active participants in relevant coordination meetings, mostly affiliated under the umbrella of the MoH:

- National Incident Management System (IMS) social mobilization subcommittee;
- Montserrado County IMS group;
- Community Health Technical Working Group;
- Health Restoration Working Group;
- Health Promotion Technical Working Group;
- Cross Border Working Group; and
- Research, Monitoring and Evaluation Subcommittee.

In addition, all of the ECAP partners participated in MoH county and district level health team meetings. For MoH initiatives and requests that fell within the goals of ECAP's sectors, the partners used adaptive management processes to respond (e.g., school reopening, addressing message fatigue and stigma). The

MELS staff made presentations to share information and learnings to: social mobilization; research, monitoring and evaluation; U.S. Ambassador and Congressional aides; OFDA in Washington D.C.; the West African Health Organizations 2015 Health Information Management Systems meeting and a presentation about ECAP and adaptive learning to USAID's Policy, Planning and Learning and Collaborating, Learning and Adapting Groups in Washington D.C.

The MELS system, with its core rapid KAP survey and partner activity monitoring tools, is an ambitious and innovative program monitoring, evaluation and learning system, especially in the context of being implemented during an emergency. It has used digital technology (via smart phones) through a broad distributive channel (the ECAP network) to capture data, provide a dynamic social media interactive platform and provide immediate feedback loops for the network. It has enabled mobilizers to directly monitor the changes in the knowledge and behaviors in their assigned communities and then use this knowledge to direct their communicators to respond to the greatest needs of the community. For almost all mobilizers, this direct learning and monitoring is a new experience for them and is inculcating a culture within themselves and their organizations of adaptive management and responsive programming.

The monthly activity reports collected through the digital monitoring system also assisted partner program managers to identify the challenges faced by their mobilizers and the key issues within the communities they work in. Given the real time nature of the data collection system, managers were able to rapidly respond to these issues to support their mobilizers' and communicators' work.

To effectively manage and share information in a decentralized network, ECAP's design incorporated the important gatherings of partners to discuss issues and lessons learned. Three of these workshops were conducted during the program, including a reflection session in the final workshop at the end of the program. These workshops had more than one hundred attendees and included key representatives from the MoH, ECAP partner managers and USAID/OFDA representatives. Key learnings and reflections:

- the importance of understanding how to work together and regular coordination are critically important in consortium management;
- knowledge of local cultures is necessary to effectively reach certain communities and influence behavior change;
- using known community members (including religious leaders) to communicate is necessary to quickly mobilize and build trust;
- stigma was a challenge for all survivors and related parties and ongoing public service campaigns are necessary for reintegration and acceptance;
- encouraging and assisting communities to establish their own surveillance teams that were responsible for reporting illegal border crossing and burials to proper authorities.
- building relationships with county level health officials provided an enabling environment for ECAP implementation;
- partners gained a new understanding of the importance of M&E and are anxious to learn more; and
- many partners for the first time used data gathered from the dashboard to adjust their program activities and emphasis (adaptive management).

The detailed workshop reports are attached in Annexes

Mercy Corps and PSI Partnership

The ECAP program was led by MC in partnership with PSI. MC was responsible for linking activities into MoH coordination structures at the national level, managing the sub-granting mechanism with NGOs, implementing monitoring and evaluation processes and building and maintaining partnerships to establish a dynamic learning platform which was designed to adapt as the epidemic evolved. PSI focused on

training mobilizers, implementing a targeted behavior change strategy and supporting mass media activities that complemented the community-level mobilization.

Program Cost Effectiveness

Taking the number of beneficiaries, 2,441,599, and the size of the grant, \$12 million, it cost \$4.91 per person to help 2.4 million people engage in behaviors that avoided contracting EVD and transmitting it. Total head count working on the program were: 574 people employed by partners, PSI and Mercy Corps; 804 mobilizers; 14,719 communicators for a total of 16,097. For the grant size, it cost \$745 per person to implement the program. Subgrants to implementing partners amounted to \$7,402,642 and the PSI award was \$2,082,431. The Paul Allen Foundation donated 1,000 LG Smart Phones which were used by the MEIs team and all mobilizers to gather program data, engage in digital channels and take photos and videos in support of program documentation. The community radio segment of the program, implemented by IREX, reached thousands of listeners with messaging to promote healthy behaviors and safe practices, reinforcing work on the ground in stopping the transmission of EVD. The open access dashboard and the data collection tools were designed in-house and then built by a software engineer in India who charged approximately \$10,000, a significant savings when compared to other world markets in this sector (work can run upwards from \$50,000). Considering program scale, ECAP was implemented very cost effectively.

Recommendations for Program Design Improvement

The sub-contracting component of the program which essentially devolved the implementation of it to 77 civil society organizations was innovative and powerful because it had never been done in an emergency setting and it supported the scale of the program. Having experienced the efficacy of this approach when a large number of people need to be reached immediately, the program could have been improved by having more flexible rules for sub-grants. As an example, Mercy Corps was unable to increase the amount of the sub-grants for partners to review their work and their organizations and to have a significant learning event for their mobilizers and communicators. This activity was not originally contemplated and was not an activity identified in the sub-grants. Because of the inflexibility of the sub-granting rules and time constraints, this activity could not be added because of time consuming new grant agreements and approvals. Because of this, Mercy Corps had to organize a large, central event and most mobilizers and communicators could not attend. There was one partner that had other funding and did organize an event in the field with mobilizers and communicators and to not have been able to support this activity for all of the partners was a missed opportunity for capacity building and learning.

The lack of connectivity throughout the country was not fully understood and accommodated in program design. An improvement would have been to more fully integrate the mass media, community radio component into partner activities. This design improvement has been incorporated into the follow on ECAP program and smart phones will be replaced by tablets for ease of data entry and readability.

Challenges

The ECAP program worked through the largest network of local and international organizations in Liberia tackling the Ebola epidemic. While this offered the opportunity for scale, it also offered challenges, including:

- efficiently and accountably issuing sub-grants to many organizations that MC had not worked with before;
- many of the partner NGOs did not know each other and had never been in this type of network;
- many partners had a diverse approach in delivering messages, making it difficult to maintain message fidelity at times; and
- the difficulties inherent in decentralized implementation by 77 NGOs in a centralized, government-led national emergency response because they:

- had not used digital technology in program implementation before,
- had not been exposed to the LLA methodology, and
- had not been exposed to a relatively sophisticated MELS.

While it would appear as if these challenges would present an insurmountable obstacle to achievement of the program's goals, they did not. What was challenging is the lack of connectivity in wide swaths of the country and the difficulty of road and other transportation networks to access communities. The partners came up with some short-term solutions to meet these challenges (batching the phones so one person downloaded in a connected location, climbing trees to search for a signal, creatively finding resources to aid in the transport of communicators), but for further programming these constraints will need to be addressed. (The country is daily making progress on a number of fronts, so we anticipate that travel conditions will become better over time.) The other challenge was that many of the mobilizers and NGO managers needed additional training in using the smart phones to upload data and then understand what the data was telling them. During the no-cost extension (NCE) period (April – July), the NGOs were assisted with this aspect of the program.

Although there were challenges of managing a program of ECAP's scope in an emergency response, MC, PSI and IREX, together with the 77 partner network, managed to reach 2.4 million people, or 56% of the total population, with messages to prevent the spread of Ebola. The ECAP program contributed greatly to Liberia's success in turning back the spread of this deadly disease.

ANNEXES

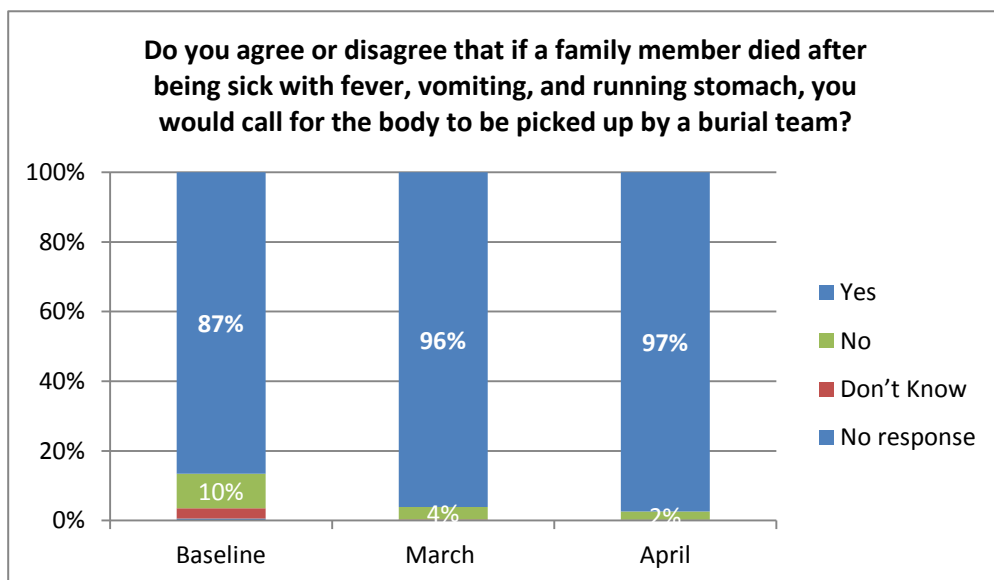
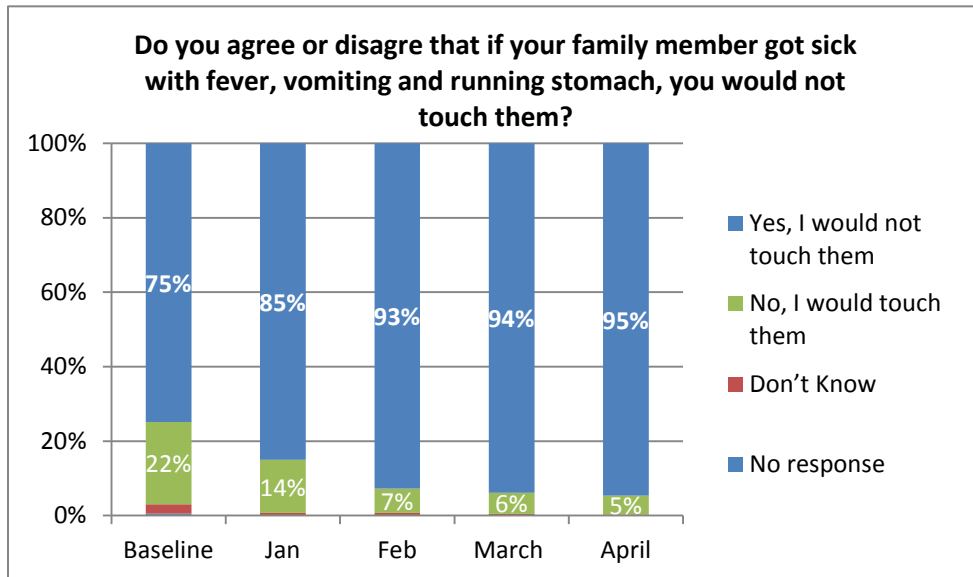
- I. MELS Data**
- II. ECAP Partner Listing**
- III. Rapid Research Reports**
- IV. Lessons Learned and Self Reflection Report from 3rd and Final Workshop**
- V. Success Stories**
- VI. Select Program Photos and Captions**
- VII. PSI Final Report**

ANNEX 1: MELS Indicators on Behavior, Stigma, Transmission Knowledge and Program Reach

MELS DATA

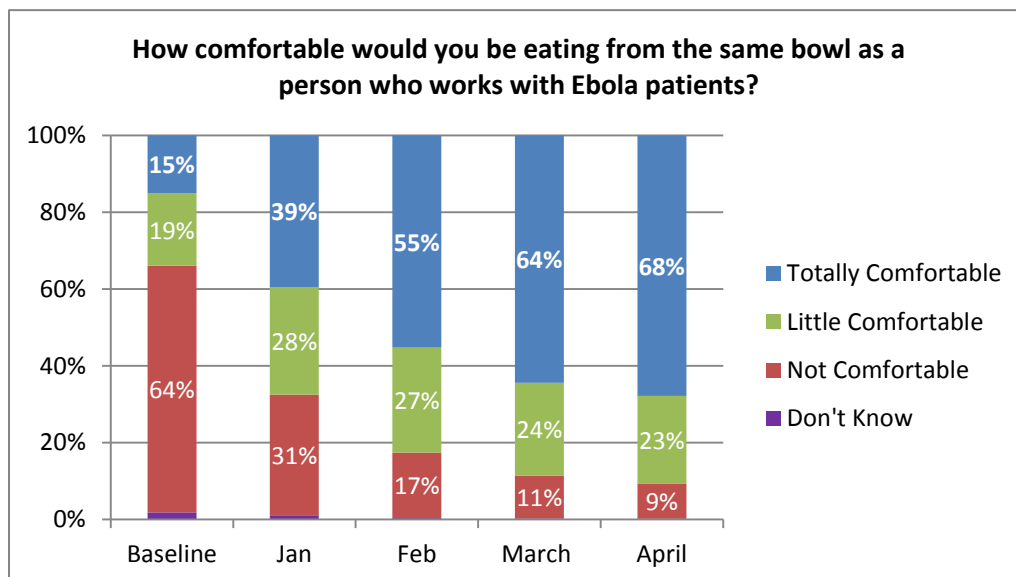
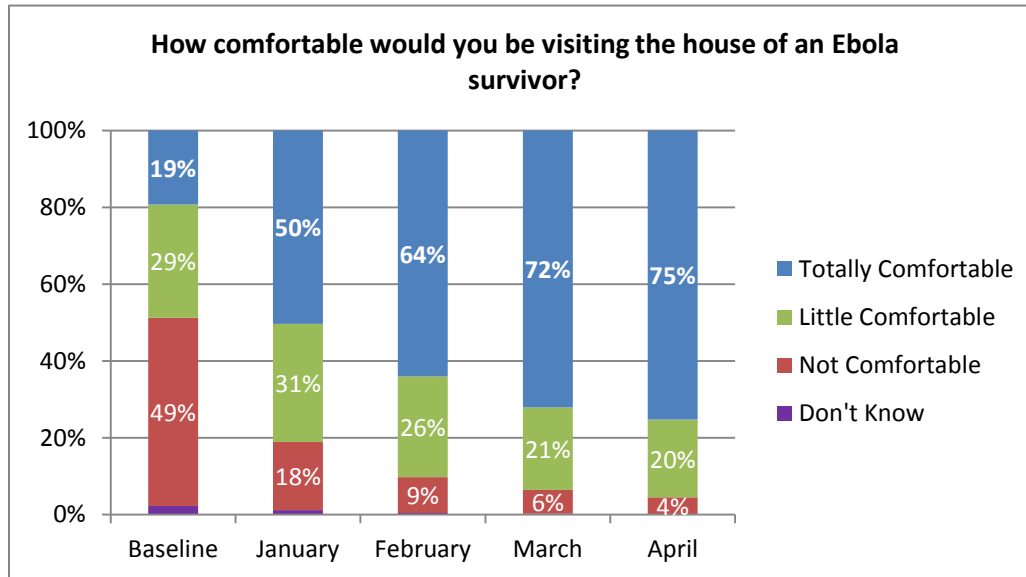
1) % of beneficiaries who adopt practices to protect themselves against Ebola

95.2% of beneficiaries have adopted 'non-touching practices' to protect themselves Ebola, whilst 97.4% have adopted 'help seeking' practices. This reflects an improvement of 25.4% and 11.0% respectively.



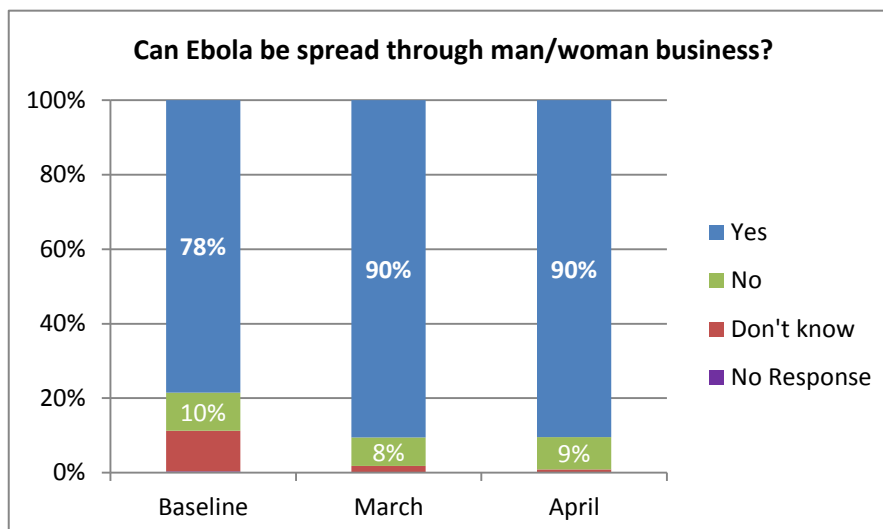
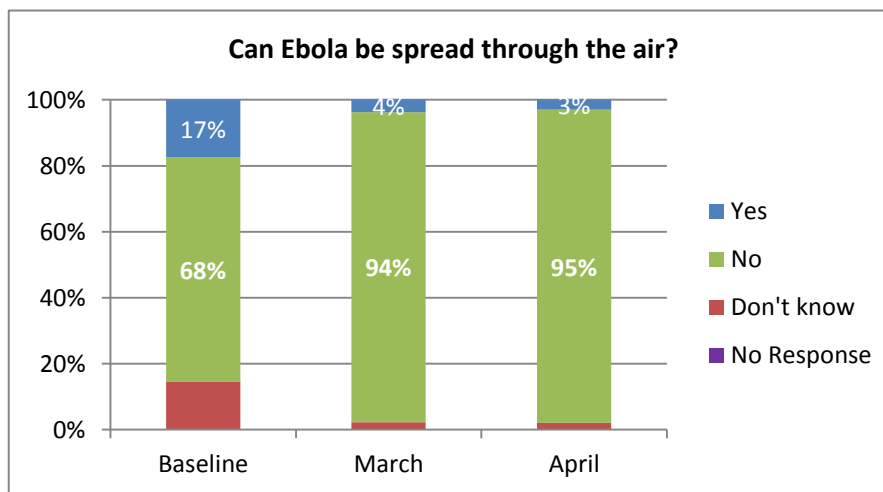
2) % change in stigma towards Ebola survivors and Ebola workers

75.2% of beneficiaries have adopted 'non-stigmatizing' behaviors towards Ebola survivors, whilst 67.7% have adopted these 'non-stigmatizing' behaviors towards Ebola workers. This reflects a 293% and 352% improvement in stigmatization behaviors since the Baseline.



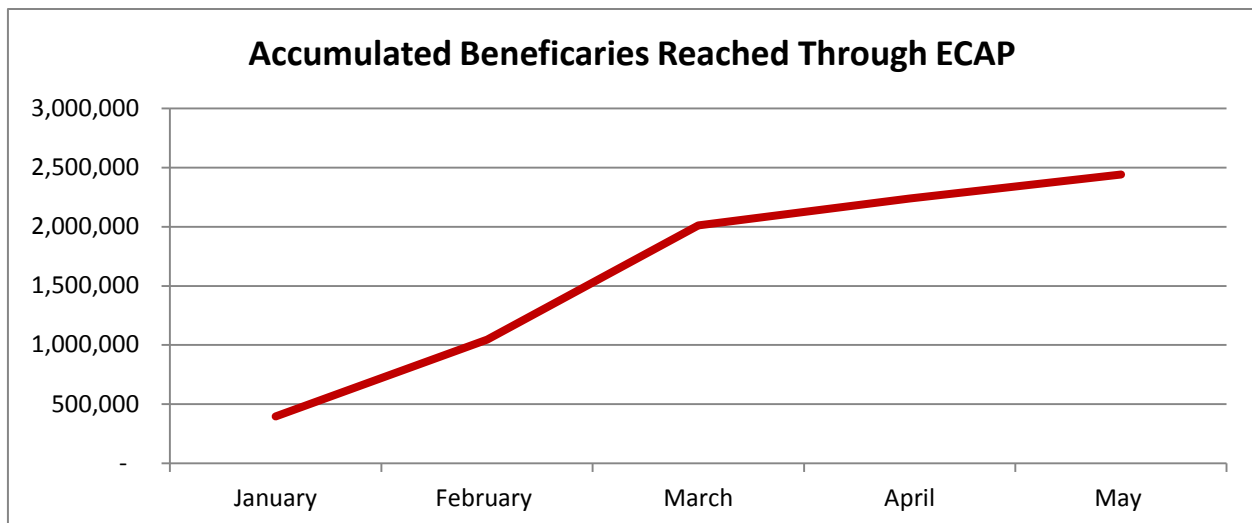
3) % change in Ebola knowledge

95.0% of beneficiaries have developed an understanding that Ebola is not spread through the air, whilst 90.4% of beneficiaries are now aware that Ebola can be spread through sexual intercourse. This information is reinforced by similar improvements in other questions on Ebola transmission. These results reflect improvements of 40% and 15% in knowledge on Ebola transmission since the baseline.

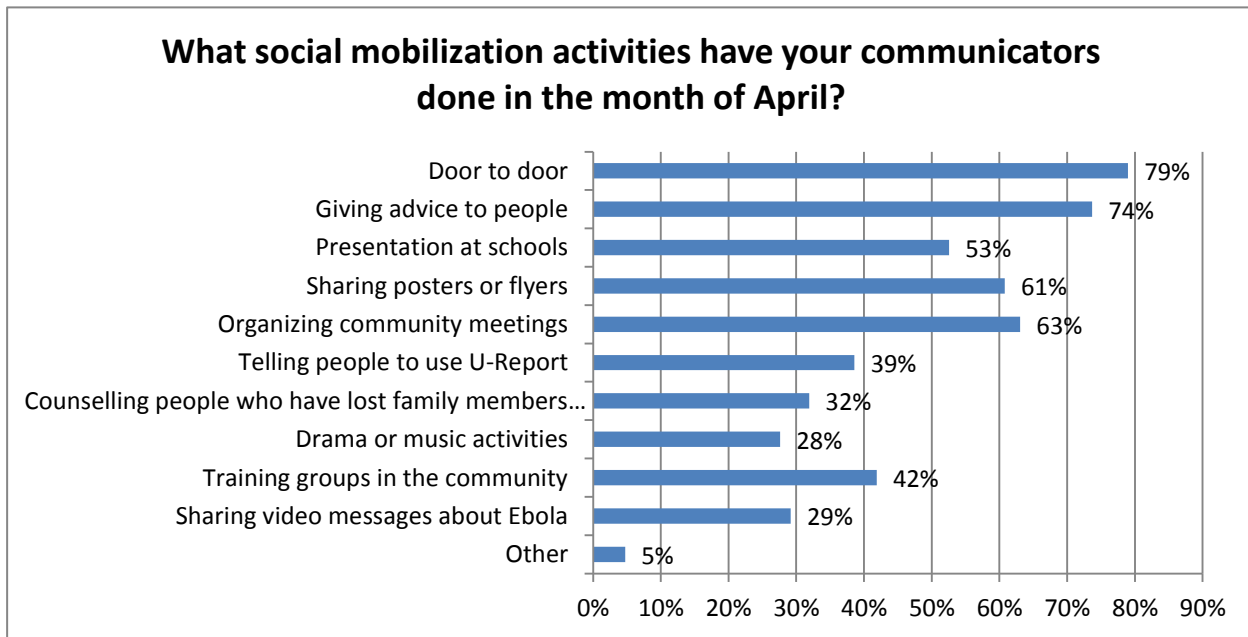
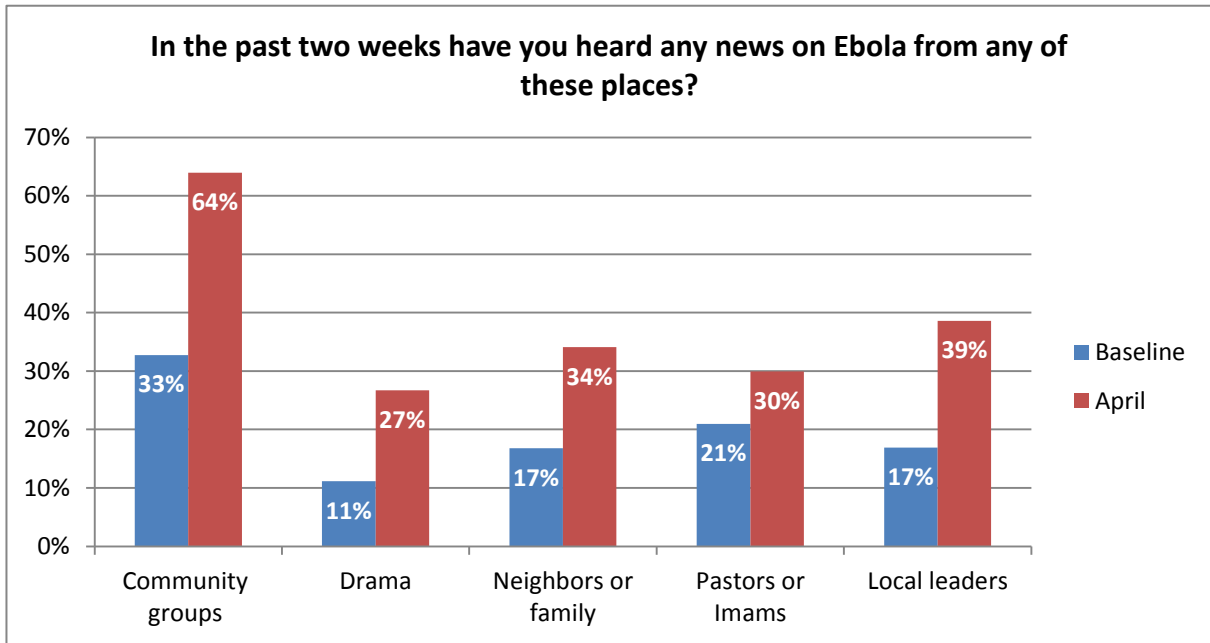


4) *Program reach and coordinating partners*

The ECAP Program reached a total of 2,441,599 beneficiaries through community based social mobilization and behavior change techniques. The program reached such a large number of beneficiaries through engaging community groups and individuals directly within communities to conduct the social mobilization. This resulted in individuals receiving information on Ebola through their family, friends, neighbors, local leaders, religious leaders and through role plays and dramas within communities. See the graph below to see the change in community members' sources of information after the ECAP program began. Additionally, the individuals communicating the messages used a variety of different tools to do so, the various tools used and the extent to which they



were utilized is demonstrated in the final graph at the bottom.



ANNEX II: Partner Listing

Under the ECAP Program, Mercy Corps has 77 official sub-partners. The full list of 77 partners is included below including the background of their NGO work. In addition to the 77 sub-partners, Mercy Corps also partnered with PSI/Liberia and IREX.

	<i>Organization</i>	<i>International NGO/Local NGO</i>	<i>Lead Partner/ Sub- Partner</i>	<i>Area of Focus</i>
1	Concern Worldwide	International	Lead Partner	Broad based
2	Finn Church Aid	International	Lead Partner	Broad based
3	Women's Campaign International Liberia	International	Lead Partner	Women focused NGO
4	ZOA International	International	Sub-Partner	Broad based
5	Centre for Liberian Assistance	Local	Lead Partner	Women focused NGO
6	Last Mile Health	Local	Lead Partner	Health
7	Women NGOs Secretariat of Liberia (WONGOSOL)	Local	Lead Partner	Women focused NGO
8	YMCA Liberia	Local	Lead Partner	Youth led NGO
9	Lutheran Church of Liberia	Local	Lead	Health

			Partner	
10	NAYMOTE - Partners for Democratic Development	Local	Lead Partner	Peace building
11	National Mandingo Caucus of Liberia	Local	Lead Partner	Health
12	Platform for Dialogue and Peace (P4DP)	Local	Lead Partner	Governance
13	Positive Change for Women and Girls Initiative (POCHAWOIN)	Local	Lead Partner	Women focused NGO
14	People United for Sanitation Health (PUSH)	Local	Lead Partner	Health
15	RECEIVE	Local	Lead Partner	Governance
16	VOSIEDA	Local	Lead Partner	Governance
17	Zorzor District Women Care Inc (ZODWOCA)	Local	Lead Partner	Women focused NGO
18	Community Health Education & Social Services (CHESS)	Local	Lead Partner	Health
19	EQUIP Liberia	Local	Lead Partner	Health
20	Mano River Union Youth Parliament - Liberia Chapter	Local	Lead Partner	Youth led NGO
21	Vision Awake Africa for Development/More Than Me	Local	Lead Partner	Education
22	RESPECT Liberia	Local	Lead Partner	Education
23	Survivors Aid International Liberia (SAIL)	Local	Lead Partner	Economic development
24	West Africa Network for Peacebuilding (WANEP)	Local	Lead Partner	Peace building
25	Youth in Action for the Prevention of HIV & AIDS (YAPA)	Local	Lead Partner	Youth led NGO
26	Youth United for Development Association (YUDA)	Local	Lead Partner	Economic development
27	Liberians United for Rescue Action (LURA)	Local	Sub-Partner	Economic development
28	Community Youth Nation Program (CYNP)	Local	Sub-Partner	Youth led NGO
29	Concern Aid International (CAI)	Local	Sub-Partner	Health
30	Grassroots Agency for Social Services (GRASS)	Local	Sub-Partner	Agriculture
31	The Liberian Red Cross Society	Local	Sub-Partner	Health
32	National AIDS Commissions (NAC)	Local	Sub-Partner	Health
33	Women Movement for Sustainable Development (WOMSUD)	Local	Sub-Partner	Women focused NGO

34	FACE Africa	Local	Sub-Partner	Health
35	Bassa Women Development Association (BAWODA)	Local	Sub-Partner	Women focused NGO
36	Women Care Initiative (WOCI)	Local	Sub-Partner	Women focused NGO
37	Leadership Institute for Women (LIFW)	Local	Sub-Partner	Women focused NGO
38	Margibi Women Development Association (MARWODA)	Local	Sub-Partner	Women focused NGO
39	Community Safety Initiative	Local	Sub-Partner	Peace building
40	Special Emergency Activity to Restore Children's Hope (SEARCH)	Local	Sub-Partner	Health
41	A2N-Africa 2000 Network	Local	Sub-Partner	Agriculture
42	Project New Outlook	Local	Sub-Partner	Health
43	Rural Human Rights Activist Programme (RHRAP)	Local	Sub-Partner	Governance
44	Sustainable Livelihood Promoters Programmes (SLPP)	Local	Sub-Partner	Economic development
45	Forum for African Women Educationalists (FAWE)	Local	Sub-Partner	Women focused NGO
46	Community Development and Research Agency	Local	Sub-Partner	Peace building
47	Gender Peace Network Liberia	Local	Sub-Partner	Peace building
48	Youth in Technology and Art Network (YOTAN)	Local	Sub-Partner	Youth led NGO
49	Southeastern Women Development Association (SEWODA)	Local	Sub-Partner	Women focused NGO
50	CSO Consortium on Natural Resource Management (NRM)	Local	Sub-Partner	Governance
51	People Empowerment Program (PEP)	Local	Sub-Partner	Education
52	Fore-runners of Children's Universal Rights for Survival (FOCUS)	Local	Sub-Partner	Governance
53	Bomi County Citizen Advocacy Union (BOCAU)	Local	Sub-Partner	Governance
54	Center for Trauma Healing and Reconciliation (CE-THRP)	Local	Sub-Partner	Health
55	Bomi Women Development Association (BOWDA)	Local	Sub-Partner	Women focused NGO
56	MUFVAWAC	Local	Sub-Partner	Governance
57	Radio Bomi FM 98.9	Local	Sub-Partner	Other
58	Peacebuilding Hub Liberia (PHuB)	Local	Sub-Partner	Peace building

59	Liberian Crusaders for Peace	Local	Sub-Partner	Peace building
60	SHALOM INC	Local	Sub-Partner	Health
61	Christian HIV/AIDS Network of Liberia (CHANOL)	Local	Sub-Partner	Health
62	Reproductive Health Group-Liberia (RHG-L)	Local	Sub-Partner	Health
63	Trauma Aid International	Local	Sub-Partner	Health
64	Give Them Hope	Local	Sub-Partner	Health
65	Afro-Medical Community Health and Welfare Services (ACHWS)	Local	Sub-Partner	Health
66	Action Development Initiative International (ADII)	Local	Sub-Partner	Broad based
67	Capacity for Youth	Local	Sub-Partner	Education
68	Society for Poverty Reduction	Local	Sub-Partner	Economic development
69	Grand Gedeh Modern Artist Production (GMAP)	Local	Sub-Partner	Other
70	Liberian Youth Network (LIYONET)	Local	Sub-Partner	Youth led NGO
71	Candace Girls Educational Foundation	Local	Sub-Partner	Education
72	Women Protecting Female Inmates and Welfare Inc (WOPROFIW)	Local	Sub-Partner	Women focused NGO
73	Ballet Gedeh Rooster Inc	Local	Sub-Partner	Other
74	AMU WULU Forum	Local	Sub-Partner	Peace building
75	Grand Kru Women Development Association (GRAWODA)	Local	Sub-Partner	Women focused NGO
76	Women in Peacebuilding Network Pleebo Branch (WIPNET)	Local	Sub-Partner	Women focused NGO
77	National Rural Women's Program	Local	Sub-Partner	Women focused NGO

ANNEX III: Rapid Research Reports

Ebola Community Action Platform (ECAP) Program Assessment April – May, 2015

The sector 1 objective of the ECAP program is to enhance awareness and uptake of behaviors which reduce EVD transmission through community-led and national social mobilization activities. The core messages centered on basic information about Ebola Virus Disease (EVD) signs, symptoms, spread and transmission, health seeking behaviors, Ebola Treatment Units (ETU) and stigma.

Approach and Methodology

Objective

The research was designed as a qualitative assessment of beneficiaries perception of the ECAP program performance. The results will serve primarily to improve future performance and validate known successes of the program.

The study had four focus areas:

5. **Knowledge uptake:** Was there knowledge uptake in ECAP communities? If so, on what topics was there greatest knowledge uptake? How did the ECAP methodology contribute to this knowledge uptake?
6. **Behavior change:** Was there behavior change in ECAP communities? If so, in what areas did this occur? How did the ECAP methodology contribute to this behavior change?
7. **Community action:** Did communities take internal action to protect themselves from EVD? If so, what types of action took place? Can this action be linked to ECAP's presence in the community?
8. **Future community concerns:** What concerns remain in communities? Does messaging need to be reinforced? If so, in what areas?
- 9.

Methodology

This assessment was conducted in April-May 2015, focusing on activities in 10 counties, where a majority of ECAP activities occurred. To ensure the accuracy and reliability of the findings, data was collected in communities where the ECAP program was implemented and in communities where ECAP was not implemented. In total, data was collected from 40 communities where ECAP was implemented ('ECAP Communities') and 20 communities where ECAP was not implemented ('Non-ECAP Communities'). Communities were randomly selected through a consultative process with all ECAP partners in the county, and took into consideration partner's distance from the principal city (maximum 3 hours' drive + walk if required) and road access to the community. Non-ECAP communities were identified with the assistance of Partners based in the counties.



The primary tools used in this assessment were key informant interviews, focus group discussions (FGDs) and observations. The interviews and focus group discussions were conducted with individuals within the

communities, they were not conducted with Partner staff or anyone directly involved in the ECAP program. The Focus group discussions were of mixed gender and had 10-12 participants in each group.

The tools employed were substantially the same for both ECAP and Non-ECAP communities.

Limitations

There are inevitable limitations to a solely qualitative assessment of program impact. With the data collected solely post-program it is difficult to independently verify the accuracy of participant report information uptake and behavior changes. Additionally, it is hard to verify the sources of the uptake and behavior changes and as a result assign credit to the ECAP program. The assessment team used triangulation of data findings, including examining the quantitative KAP data, to minimize the risk of this occurring. Furthermore, the methodology employed the use of a counterfactual to try and address any data quality issues that arise through this limitation.

An additional limitation of this assessment is its cross partner nature, given the variation in implementation techniques across partners. However, given the aim of the assessment was to gain insight into the overall program outcomes, this could not be avoided.

Findings and Analysis

A. Knowledge Uptake

Was there knowledge uptake in ECAP communities? If so, on what topics was there greatest knowledge uptake? How did the ECAP methodology contribute to this knowledge uptake?

What knowledge was gained?

The assessment found high knowledge levels in ECAP communities on a majority of the Ebola related messaging topics. The knowledge level in ECAP communities was found to be significantly higher than in Non-ECAP communities suggesting that this knowledge uptake is a result of the ECAP program. This knowledge is an expected outcome of the ECAP program. The knowledge areas where the greatest knowledge uptake was found were:

- Ebola prevention methods: Not touching sick people, not touching dead bodies, etc.
- Personal hygiene: Washing hands, clean environments.
- Signs and symptoms of Ebola
- Ebola transmission methods.

More interestingly, the assessment found a difference in the ability of community members to explain the reasoning behind a number of basic Ebola messages. Given the widespread nature of Ebola messaging in Liberia it is expected that a majority of people can recite the Ebola related slogans, such as “wash your hands” and “don’t touch strangers”. The ECAP program aimed to go beyond these slogans, explaining the reason behind them and as a result creating behavior change.

The assessment found that community members from ECAP communities could explain the “why” behind the messaging, whilst those from Non-ECAP communities could not. For example, community members in ECAP communities could explain that they have to wash their hands with soap or chlorine because the virus can live on their skin along with other germs and the soap/chlorine will kill it during the hand washing process. Community members from Non-ECAP communities could not explain why they had to wash their hands or why soap/chlorine is meant to be used.

For example, in one Non-ECAP community, community members reported very limited social mobilization activities. A female participant asked during a FGD, “so how do people get Ebola, I have

been washing my hands until now....” It was evident that some individuals in Non-ECAP communities (i.e. the more educated male population with radios) had information on Ebola, however other members of society often had different information passed on but felt the knowledge they had was either insufficient, or not accurate.

This finding suggests that the ECAP methodology was successful in its aim of ‘explaining’ health messages to community members rather than teaching community members to recite key phrases.

How did the ECAP methodology contribute to this?

The ECAP methodology was unique in that it involved employing individuals living within the communities to conduct the messaging, and required those individuals to use PSI/Liberia’s unique behavior change methodology ‘Listen, Learn, Act.’ This methodology requires the communicator to engage the community member in a discussion, ask them questions and ensure they really understand the reasoning behind the message. Additionally, these communicators were encouraged to use a range of activities to pass this messaging on, including door to door awareness, community meetings, drama shows, video productions and announcements in school and religious centers.

“It helps us to understand the messaging because they [ECAP Communicator] sit with us to discuss and make us understand that Ebola is real.” FGD Participant, ECAP Community

The assessment found that community members within ECAP communities could identify ‘ECAP Communicators’ by the methodology they were using, that of sitting, discussing, and answering questions. Participants stated that this approach allowed them to ask lots of questions and really understand the messages. The most successful way this was done was through the door-to-door methodology used by Partners. As the ECAP communicators were living in communities they were able to respond to questions, even after the original discussion period, as a FGD participant stated “Because the mobilizer was living with us we had more knowledge on Ebola”.

This approach was identified as being different from other groups who gave brief explanations or recounted the Ebola slogans. A community member from an ECAP community compared the ECAP approach to the Ebola loudspeaker announcements another by another NGO and stated “The loudspeaker awareness was mostly done on car with music and was not really clear. We were not able to ask any questions.” Additionally, a community member from a Non-ECAP community stated in regards to the effectiveness of Ebola activities conducted by another NGO in their community “We did not get the message well because the people used to be in rush to go to another community, we were not able to ask question to get clarity on few question.” This highlights the importance of having individuals living within communities conducting the social mobilization as they are able to provide constant follow up information and answer questions that arise after the initial information is disseminated.

B. Behavior Change

Was there behavior change in ECAP communities? If so, in what areas did this occur? How did ECAP contribute to this behavior change?

What behavior was changed?

Changing behavior is a much more challenging outcome to achieve than achieving knowledge uptake and understanding. Despite this, it was a key goal of the ECAP program. The program assessment found that behavior change did occur in ECAP communities. The key behaviors that were changed were:

‘No one is getting sick like the way we used to before. I mean, we don’t get running stomach anymore.’ FGD Participant, ECAP Community – In response to why they continue to wash their hands.

- The overcoming of Ebola denial

“Reporting early sick cases has saved our families from other diseases and we must continue to do that because the health center is the right place for diagnosis.” FGD Participant, ECAP Community.

- Improved handwashing and hygiene practices
- Improved health seeking behavior (where health facilities were available)
- Reduction in stigma towards Ebola survivors.

This behavior change appeared to stem from the deeper understanding gained in the knowledge uptake process. Community members were linking the new behaviors to positive health outcomes which gave them further encouragement to keep up these behavior practices. In particular, participants were linking their improved hand washing practices to a reduction in sicknesses in their community, particularly a reduction in diarrhea and cholera among children. This motivated community members to continue to engage in these practices beyond the length of the social mobilization program. As one FGD participant stated “Even if NGO go, we will still use our Iron soap and bucket to keep washing our hands.”

The area where the impact of ECAP could most readily be seen was in community member’s behavior towards Ebola survivors in ECAP communities, compared to Non-ECAP communities. As one FGD participant from an ECAP community stated, “stigma has reduced, we are eating with survivors and playing with them now.”

How did the ECAP methodology contribute to this?

The assessment found that the behavior change occurred because of three main factors:

10. The individuals passing on the messages were trusted and were believed to be presenting truthful information
11. The individuals were persistent with their messaging and ensuring complex details were understood
12. Community members understood the reason behind why they needed to change their behaviors
- 13.

These factors link directly into the ECAP methodology of using individuals from within communities and using the Listen, Learn, Act methodology. Through using community members to do the social mobilization, the ECAP program was able to overcome any potential trust issues that often arose during the Ebola epidemic in Liberia. The ability to receive information from community members, neighbors or friends meant that individuals felt free to trust the information and adopt the behaviors suggested. As one FGD participant stated, ‘because the people [ECAP Communicator] keep in the community we were able to adopt a new behavior and keep practicing.’

Furthermore, as the individual lived in the community they were conducting constant messaging on at least a weekly basis. This not only reinforced the importance of the message, it also enabled people to ask questions and seek further information on messages as they thought of them. Being able to ask many questions and get further clarification helped develop deeper understanding of why changing their behaviors was important and would lead to benefits for themselves. As one FGD participant stated, ‘[The ECAP] Communicator visited to our home three times a week, they made us to keep washing our hands so we have kept on doing it.’



C. Community Action

Did communities take internal action to protect themselves from EVD? If so, what types of action took place? Can this action be linked to ECAP’s presence in the community?

The ECAP program did not specifically require communities to take community led action to protect themselves from a further Ebola outbreak. However, certain partners took initiative to encourage their target communities to take community led action to protect themselves.

The assessment found that some ECAP communities took action to protect themselves from Ebola. The main actions taken were:

- A taskforce established to monitor the activities and preventative measures taken in the community
- Community leaders enforced a law on hand washing and established hand washing stations in the community
- Community members agree to avoid having strangers visit and register strangers when they enter the community

“Our community leader enforced a law on washing your hands. Community members paid a fine of 500 LD if you didn’t.” FGD Participant, ECAP Community

There was no identifiable difference between ECAP and Non-ECAP communities in terms of the level of community action taken or types of action taken. The effectiveness of these community actions and the means by which they were initiated remained unclear. As a result no clear linkage can be drawn between the community action taken and the ECAP program.

Further research on this aspect is needed to provide more detail and clarification on this point. However, the little evidence collected suggests that ECAP did not majorly contribute to the development of community action initiatives across a broad range of partners.

D. Future Community Concerns

What concerns remain in communities? Does messaging need to be reinforced? If so, in what areas?

Topics needing message reinforcement

Despite the assessment finding high knowledge uptake, there still remains gaps where further message reinforcement is needed. In particular, the topics of stigma to health care workers and survivors and topics on how survivors can spread Ebola need further reinforcement.

Stigma towards Health Care Workers and Ebola Survivors: The majority of participants understood and believed that Ebola survivors could not transmit Ebola, except through sexual intercourse. However, despite this high level of understanding, and the rapid reduction in stigma levels in communities, there remains a clear gap where further sensitization could occur. Many individuals remain uncomfortable sharing a meal with survivors they had just met, however, would do so after several weeks or months of personal observation of the survivor.

Survivor transmission methods: While basic knowledge levels can be considered significantly high across all communities, participants were still grappling with the concept of how survivors could spread Ebola, particularly in regard to sexual intercourse. Many community members saw this as a reason to doubt the status of survivors and therefore limit interactions with survivors. Until a clear Ministry of Health and Social Welfare direction arises on this issue, community members will continue to be confused and stigma will continue to be a concern.

Community concerns

Communities continue to have concerns regarding their health situation. Community concerns appeared consistent across both ECAP and Non-ECAP communities. The two major concerns that arose during the assessment were concerns regarding the maintenance of Ebola safe practices and access to health care.

Maintenance of good practices: Communities reported many concerns and questions regarding the transition from the Ebola epidemic to the post-crisis stage. They were unclear as to whether they were expected to continue their Ebola prevention practices and what practices they could stop following. They were particularly concerned about culturally sensitive practices which they were keen to recommence, such as traditional burials and personal greetings. Furthermore, communities were concerned about whether the support services surrounding the epidemic would continue to be available. Of particular concern was access to safe burial services and ambulance services. These concerns suggest that further information must be clarified from the national Ministry of Health and Social Welfare and communicated down to the community level.

Access to health services: All health centers have now reopened, but services at most health facilities are still very limited (e.g. only to pregnant women). Health facilities are reportedly treating a very limited number of patients per day; this means that patients coming from far away have to start their journey as early as 5 a.m. in order to reach the health center in time to receive a patient number which entitles them to treatment for that day. If the patient is unable to reach the health clinic by the time number tickets are distributed (which is usually before 7:30 am) they are turned away and have to start the process again the next day. Generally all participants registered no fear of seeking health care at their local health facility and would go there if they or another member of their family fell ill. However, while public health facilities are free there are oftentimes no drugs and patients have to raise the money to purchase prescribed medications which many cannot afford and may have to forgo other family needs to meet the cost.

Conclusions

The ECAP program successfully met its objective of enhancing knowledge uptake and changing EVD related behaviors in communities. This was achieved through the program design of employing individuals living within target communities to conduct the messaging and using a unique messaging methodology developed by PSI/Liberia.

Despite this, there remains a need for continued Ebola related messaging particularly in relation to Ebola survivors and the means by which they can transmit Ebola.

ANNEX IV: Lessons Learned Report from 3rd Workshop and Self Reflection Report

Third Lessons Learned Workshop Report

Mercy Corps, in partnership with Population Services International (PSI) and with funding from USAID/OFDA, implemented the Ebola Community Action Platform (ECAP) from December 8, 2014 –June 15, 2015 across the 15 counties in Liberia. The goal of this project was to significantly reduce or eliminate the transmission of the Ebola virus disease (EVD) through a community-led social mobilization campaign. Mercy Corps worked with 77 partners, consisting of both local and international NGOs, to implement the ECAP project.

On June 18 & 19, Mercy Corps brought together representatives from these 77 partners to host the final Lessons Learned Workshop under the ECAP project. The objective of the workshop was to gather lessons that had been learned by these partners and other stakeholders during the implementation of the ECAP project. The workshop was held at the Golden Gates Hotel located in Paynesville with around 200 persons in attendance.

This report highlights important findings and lessons coming out of presentations, group work, speeches, and shop/booth exhibitions that were done by these partners and other stakeholders during the workshop.

Key Learnings from Partners

A. Cross border issues

- Cross border interventions remain very sensitive in post Ebola Liberia. The main reason for this is that neighboring countries are still reporting cases and the borders are very porous.
- ECAP Partners demonstrated the best approaches to managing cross border issues. These approaches involved:
 - Strengthening relationships with the Bureau of Immigration and Naturalization and supporting them where needed, particularly in relation to contact tracing and surveillance.
 - Assisting the Bureau of Immigration and Naturalization to coordinate effectively with the County Health Team.
 - Encouraging and assisting communities to establish their own surveillance teams that were responsible for reporting illegal border crossing and burials to proper authorities.
 - Recruiting community educators (communicators) from within communities to assist with overcoming language barriers and any mistrust issues.
- The ECAP Partners also identified the greatest challenges for working with border communities. These were:
 - Limited access to these communities. This means organizations must use a motorbike or walk to reach the communities.
 - Lack of WASH facilities makes it difficult for border communities to follow proper handwashing procedures
- This was presented by the following partners: CHESS, YMCA Liberia , Centre for Liberian Assistance, and Equip Liberia.

B. Consortium and partnership management

- A unique factor on the ECAP program was the number of partner organizations that operated in consortiums. These consortiums varied in size and scale with some having only two partners working in one county, and others with over nine partners working across five different counties. Through the ECAP experience these consortium leaders developed an understanding of what has worked well and what could be improved when managing consortiums.
- The partners identified the following factors as ones which contribute to successful consortium operations:
 - People working together
 - Having a shared vision
 - Trust
 - Coordinated planning
 - Strong communication channels
 - Inclusive learning environments and shared learning experiences
- Partners identified the following challenges as major impediments to consortium operations:
 - When consortium leads are late to submit partner reports, this results in funding delays. This affects all partners within a consortium, even if they submitted their required information on time or ahead of schedule. This can be very frustrating for sub-partners as they are dependent on their lead partner's performance.
 - Lead organizations did not have full control over all consortium members
 - The consortium leads had very little chances of dropping a sub-partner from the project implementation after the ECAP contract was signed. This became a major issue when certain sub-partners proved to be non-performers as little could be done to manage them.
- This was presented by the following partners: SAIL, Concern International, RESPECT Liberia, Finn Church Aid, WONGOSOL.

C. Developing relationships with the County Health Team

- A strong relationship with the County Health Team (CHT) is essential for effective operation in the Liberian Ebola Response and was also a key reporting criteria for all ECAP partners.
- The ECAP Partners identified the CHTs as an ideal platform to generate adequate support and response capacities to prevent or address major and wide range of health crises. They also found them to be useful sources for County level coordination to ensure duplication does not occur among partners.
- The Partners identified the following factors as key to developing a successful relationship with the CHT:
 - Involve the CHTs in the planning stage of the intervention
 - Include the CHTs in continuous program monitoring
 - Be aware that CHTs do not have adequate logistics and materials to conduct social mobilization and other activities on their own
 - Continuously develop strategies to keep the CHTs motivated to coordinate. Identify where you can support them if possible.
- This was presented by the following partners: PUSH, National Mandingo Caucus of Liberia, and Last Mile Health.

D. The Reopening of Schools

- During ECAP Partners collaborated with the County Health Teams, the Ministry of Education, and UNICEF to conduct the joint training exercises of School Workers on the 'Safe School Protocol'.

- Partners identified the following challenges that arose during the re-opening of schools:
 - Controlling the nursery students to avoid exchanging foods and materials was very difficult and there were limited measures that could be put in place to stop this.
 - A number of schools lacked wells and hand pumps making it difficult to enforce hand washing procedures.
 - Some school authorities deliberately congested their classrooms for monetary gains. This act led to a high risk of students coming into close contact with others who might have been showing signs or carrying the EVD
 - The teacher-student ratio of 1:45 students is not in place in all classrooms, making it difficult for close contact to be limited between students.
- This was presented by the following partners: YAPA, PEP, RECEIVE, and Mano River Youth Union Parliament Liberia Chapter.

E. Working with special groups

- The ECAP Partner network contained a range of partners that had specialized skills in specific areas. ECAP was fortunate to have a number of partners with a specialization in working with specific groups of individuals, in particular Traditional Leaders and Ebola survivors. The Partners with these specialized skills gave an update on their work with these groups throughout ECAP.
- Working with Zoes, Elders and Traditional Leaders
 - Partners worked in communities where traditional practices like washing dead bodies and the Sandi society (bush school) are commonly practiced. They got traditional leaders, who are trusted and influential people, involved in social mobilization as a way to have smooth operation. Due to their involvement, it was easy to spread the anti-Ebola messages across their areas of operation.
 - Traditional and religious leaders also used their places of worship to create awareness during the implementation of the project
 - This was presented by the following partners: Zodwoca and Yuda.
- Working with Ebola Survivors
 - The partners working with survivors found they could better address stigma issues within communities through using survivors as communicators and mobilizers.
 - The partners found survivors to be effective tools to address stigma because by sharing their personal stories and giving advice they caused community members to respect survivors and also helped survivors overcome self- stigma and pity.
 - Partners also used the ECAP program to provide support to survivors such as psychosocial counselling and receiving food items. Using emotional expressions to welcome survivors was very effective. Although some survivors need food and non- food items to support integration, many survivors just want hugs, visitations and interaction from their neighbors to feel welcomed again.
 - This was presented by the following partners: Naymote and the Lutheran Church of Liberia.

Key Learnings from Mercy Corps

A. Grants and Compliance: Common Areas of Non-Compliance

- The Mercy Corps Grants and Compliance Manager conducted a capacity building presentation for partners on USAID Compliance challenges. The presentation highlighted common areas of non-compliance under USAID programs.
- The presentation identified the following areas as challenging areas of non-compliance:
 - Cost principles
 - Supporting documentations
 - Questionable/questioned costs
 - Segregation of duties and organizational structures
 - Control over assets; Fixed assets register, physical inventory, assets reconciliation and marking of assets.
 - Accounting system; Advances/Liquidations, double billing, supporting documentations.
 - Control over payroll systems; Time sheets/attendance records, personnel files/personnel manual, hiring procedures, performance appraisals.
 - Procurement procedures; Bidding process, authorizations/approvals, receiving of goods and services, threshold for competitive procurement.
 - Sub-awards management; pre-award activities, sub-grant agreements, cash disbursements, sub-grants monitoring, close-outs.
 - Documentation: Proper filing of supporting documentations, Safeguarding of supporting documents, References structure/Voucher numbering, Maintaining adequate support documents, Paid vouchers stamped "PAID", Use of Pre-numbered vouchers, Voucher numbering, record retention policy.
 - Marking and branding
 - Prior approval requirements.

B. Rapid Research: Findings of a Program Assessment

- The Rapid Research Team conducted a program assessment towards the end of the ECAP Program. Their preliminary findings were presented.
- The two key findings were that knowledge was transferred and behavior was changed through the work of ECAP Partners.
 - Knowledge gains occurred in the following topic areas: Ebola prevention methods, personal hygiene, signs and symptoms of Ebola and transmission methods. The assessment found that the methodology used, the individuals chosen to communicate the message and the communication activities selected were key factors leading to the transfer of knowledge.
 - The following behavior was changed: overcoming denial, hand washing and hygiene practices, health seeking behavior and stigma. The assessment found that the ECAP factors that led to this behavior change were the individuals passing the messages were perceived to be trustworthy, the persistency of the individuals passing on the messages and the depth of explanation within the messages.
- The assessment also found that an unintended consequence of the ECAP program was that communities were linking handwashing practices to better overall health in the community, including reduced mortality and morbidity because of the reduction in diarrhea and cholera.

C. Monitoring, Evaluation and Learning: Improving our own performance

- The Monitoring, Evaluation and Learning Manager presented preliminary results of the Partner Survey assessing Mercy Corps and PSI/Liberia's performance as managers of the ECAP sub-

granting program. The survey focused on assessing program design, training quality, communication throughout the program, troubleshooting support and data and program learning.

- The preliminary results suggested that Partners appreciated the program model and training methodologies used. They believed the freedom they were given allowed them to tailor the program implementation to respond to their strengths as individual NGOs.
- The results also suggested that Mercy Corps needed to improve its communication and time management with Partners to ensure all information is passed on to them in a consistent manner and that they meet program targets on time. Mercy Corps is continuing to collect the anonymous surveys of partners to ensure they can adequately reflect and learn from Partner feedback.

ANNEX V: Success Stories

Success Story: Tough Choices That Saved Lives in Lofa County.

Every two years, an estimated 10,000 young people are enrolled in traditional 'Bush Schools' across Zorzor District in Lofa County, where young people are oriented more about their culture in preparation for adulthood. Surprisingly, there has been no any case of EVD amongst 'bush school' learners in the district compared to their counterparts attending similar 'bush schools' in the neighboring country, Guinea which share borders with Lofa country. This was largely attributed to lifesaving social mobilization, awareness and behavior change messaging that has been disseminated by local mobilizers and communicators through Zorzor District Women Care (ZODWOCA), one of E-CAP sub grant partners in Lofa County.



ECAP team (Ishmeal and Yuconjay) Discussing with ZODWOCA officials and the Town Chief in the little stream that separates Liberia from Guinea

Further, Residents of Gezeboiga Town, in the Northern part of Lofa County, right on the border with Guinea where new cases are still being reported have adopted and demonstrated appropriate behavior and have been taking keen measures to prevent the spread of the EVD disease. The town marks one of the porous, illegal entry point that has no immigration officers assigned to monitor travelers movement between the two countries. The town has a primary school that also caters to several students residing in both Liberia and nearby villages in Guinea. Gezeboiga is a trade route where many cross-border petty traders from Guinea travel through to sell and buy goods from Zorzor market on daily basis. All of these makes Gezeboiga is a very vulnerable community that needs more attention. Realizing this, ZODWOCA has been carrying out awareness campaigns in this community



Above: ECAP Team (Ishmeal Flomo – in orange T shirt, and Yuconjay Barchue – in black and blue top) Listening to residents of Gezeboiga as they narrate their success story during a field visit in May 2015

During ECAP team's visit to Gezeboiga Town, there was rumors that at least 2 suspected new cases of EVD had been reported around a clan in neighboring Guinea just 22 Km away and the community was very alert. There was also news that a 35-year old man had resulted to committing suicide in the same area (in Guinea) after coming down with Ebola-like symptoms. A group of contractors from Guinea who had been hired by a resident of the town to build a house had been chased away after being discovered by residents that they were not observing appropriate

practices laid down by the community and town leadership such as regular hand-washing. They had been caught openly preparing bush meat for their meal and shaking hands with other Guineans who would pass in the town. This is what ECAP is about – communities taking actions to stop Ebola and making tough choices to save lives is part of it! And shows the high level of denial, ignorance and risk of EVD spreading among communities in Guinea as compared to communities in Liberia where ECAP partners have been working.

In Their Own Words

"My brother died of [Ebola](#) last year at an Ebola Treatment Unit (ETU). Since his death, my community and I thought the ETU was a death sentence and we resisted anyone who talked to us about Ebola. But then CHES Mobilizer Yenpue Mahn talked to me about the ETU after church service. She told me that at the ETU you eat three times a day, you can call your family, family visitation is allowed and conditions at all the ETUs have improved. Now I have joined sister Yenpue to spread the good news. I don't want to see anybody suffering from Ebola as we did before."



Mamie Gibson, Maryland, works in 6 communities

"In one of my communities, frankly when I entered, there was not a single hand washing station or bucket at any home. That made me scared. I was deeply worried. I decided to focus my campaign on washing hands. I carried that same message for days because I didn't want anyone to miss out on it. What gave me joy about that community is that when I went back there after couple of days, I was impressed when I started seeing buckets and bottles in front huts for washing hands. The community members started telling me thank you for bring that message to them. I was impressed.

“I started to talk to them about other things like gatherings. I saw a group of women in a gathering and drinking wine from one glass, eating ‘kola’ from the same plate and licking their hands. To me, that was scary also. I explained to them that it was risky to drink from the same glass at this point in time that we are faced with this disease which is spread to body fluids like saliva. I also told them that if they must obey their tradition of eating ‘kola’, then they all use separate spoons and everyone should put their fingers in the plate. They respected that and I saw everyone with their spoons the next visit I made there.

“I feel proud reaching out because I know some of the people don’t speak and understand English and I do speak the local dialects around here. So when I go to them, I speak the dialect they understand. In that way, they understand me more and are able to share with me how they think about Ebola.”

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Wa-Nyebo Neufville, Maryland

“One of the major challenges we were facing was about the ETU. People were against the building of ETU in the county. They saw it as a government attempt to bring Ebola in Maryland. It was hard to convince them. We taught them about the ETU. We showed them pictures of inside and outside the ETU. We even encouraged some of them to go around the ETU and see what happens there and ask questions. We didn’t take one day or one moment to pause. We talked and talked and talked. Now, I can say about 80% of the people see the ETU as important.

“You see, we all agree and are willing to kick Ebola out of Liberia. I will continue this work because nobody knows when Ebola will finally go. And when I see people changing their behaviors like this, it gives me more strength to continue and want to do more.”

ANNEX VI: Select program photos and captions



Above left: A young girl washing her hands before entering into a classroom at Martuaken Community School in River Gee County.

ECAP promoted appropriate hygienic behaviors to prevent the spread of Ebola Virus Disease.



Above right: Mobilizers and communicators carrying out a health campaign in Voinjama, Lofa County.

Various channels were used such as posters, drama, dance video shows, community radios, and town hall meetings to pass on the preventive and life-saving health messages.



Above left: Community mobilizer in Bong County talks to farmers on how to prevent themselves from Ebola during the rainy season.

ECAP Followed community members wherever they were to deliver the message 'Ebola Must Go!'



Above right: ECAP mobilizers using canoes to cross Yarh River in Nimba County.

Through trusted individuals in the community, ECAP was able to reach remote communities with messaging.

ANNEX VII: PSI Final Report



**Ebola Community Action Platform
(E-CAP)**

**Sub award agreement number: NO. PSI
ECAP 32578S001**

***Final Program Report
October 2014- June 2015***

Overview:

Background:

The 2014 Ebola outbreak in West Africa was the largest Ebola epidemic in history, with 300 to 400 cases reported weekly during the height of the outbreak². Though the outbreak started with only a few cases during March of 2014, the numbers quickly escalated and a coordinated response was needed. In a country with a weak health system and limited emergency response capacity, the case count quickly grew. The initial response from the government and international partners revolved around the construction of short-term health facilities, but in the end, the reduction in cases was the result of work done by communities in Liberia. The World Health Organization states that "health officials and their partners were quick to recognize the importance of community engagement. Health teams understood that community leadership brings with it well-defined social structures, with clear lines of credible authority. Teams worked hard to win support from village chiefs, religious leaders, women's associations, and youth groups." The E-CAP project was designed to focus on these community structures and local partners, as a way to compliment the emergency response done through treatment facilities and medical response.

Program Design:

The Ebola Community Action Platform (E-CAP) project was launched in October 2014, during the height of the Ebola outbreak in Liberia. August through October of 2014 reported the highest number of cases in Liberia, before a slight decline in November 2014. The E-CAP project was a social mobilization campaign implemented from November 2014 until June 2015, focusing on Ebola preventative messages and actions. The project was a joint effort designed by Mercy Corps and PSI/Liberia involving 77 partner organizations in Liberia, the majority of which are based in the communities. The project utilized partner organizations to spread behavior change communication through a variety of techniques in communities across Liberia.

The project was structured with Mercy Corps managing the overall project and partner organizations, while PSI/Liberia was responsible for the technical content of the project. The PSI/Liberia team facilitated trainings throughout the project to partner organizations, who then passed on lessons learned at these trainings to community-based health workers. The community-based health workers or "Communicators" were employed by partner organizations and were often from the communities where they were based, instilling a sense of trust from community members. The trainings were primarily focused on recognizing the signs and symptoms of Ebola, creating action plans in response to Ebola outbreaks, and preparedness for future outbreaks. Throughout the evolution of the outbreak, the project also incorporated messages related to the reduction of stigmatization, border surveillance, and the re-opening of schools.

Methodology:

The PSI/Liberia team developed an adult participatory learning technique called "Listen, Learn, Act," which was used during the initial trainings and the refresher trainings of E-CAP. This technique coupled with health education materials, was used by Communicators to promote positive behavior change as it relates to Ebola. The cascade style of training allowed for PSI "Facilitators" to train "Mobilizers," who

² World Health Organization, 2015

worked for partner organizations, who in turn trained "Communicators" from Liberian communities. The methodology required that the Facilitators first listen to the concerns of the audience regarding any topic related to Ebola, such as fears surrounding the use of Ebola Treatment Units. After the facilitators listened to the concerns of the audience they then taught messages ("Learn") based off this feedback, using Ministry of Health approved messages. The training manual was developed prior to the trainings, but the Facilitators were taught how to adapt their responses based on the "Listen" phase of the trainings. Finally, the "Act" phase of the training required that audience members develop an action plan to use in communities and implement activities pertaining to the lessons learned during the day. This action plan could be anything from ensuring that all households have hand-washing stations to assisting in the re-opening of health facilities during the restoration phase.

Trainings:

Overview

The E-CAP trainings started in November 2014 with PSI/Liberia conducting trainings with partner organizations on the five Ministry of Health approved messages. These messages included: do not touch dead bodies, always wash your hands with soap or chlorine, report all suspects, isolate suspects with food and water, and report to the Ebola Treatment Unit. The trainings were conducted across Liberia in two day sessions performed by the PSI/Liberia Facilitators and included Mobilizers from partner organizations, who were then disseminated information to Communicators. Partner organizations were given "Safe Burial" story-boards to use as a teaching tool in communities, along with wristbands promoting the "Listen, Learn, Act" methodology. In total, 42 initial trainings reached 918 Mobilizers from 77 partner organizations.

The E-CAP Refresher trainings complimented the initial round of trainings and focused on existing messages, along with any new Ebola messaging from the Ministry of Health. The trainings ran from February 2015 until April 1 2015, working with the same 77 partner organizations included in the initial trainings. These trainings were designed to be three days instead of two, with the first day of training being a field visit, to observe the cascade method from Mobilizer to Communicator. Additionally, the field day was used to observe E-CAP at a community level and to confirm that behavior change was occurring within targeted communities. The refresher trainings were also structurally different, in that the Partner Support Team from Mercy Corps and the PSI/Liberia Facilitators conducted the trainings together.

The Partner Support Team organized the second round of trainings geographically, so that teams were focusing on one region instead of spending additional travel days moving between counties. Ten teams, comprised of two PSI/Liberia facilitators and one Partner Support Officer, were disseminated around the country to offer a more cohesive training to partners. The PSI/Facilitators conducted the trainings using the "Listen, Learn, Act" methodology focusing on refreshing original messages and incorporating new messages related to schools re-opening, and remaining vigilant as cases decrease. The Mercy Corps team provided more in-depth trainings on the use of smart phones in health messaging and rapid data collection through the MELS system.

Objectives and Partners Reached

Objectives for E-CAP were to reach 800 Mobilizers and 10,000 communicators throughout the life of the project. These targets were surpassed as during both the initial round of trainings and the refresher trainings, 804 Mobilizers were reached and 14,719 communicators were reached (see Chart below.)

Additional project objectives included behavior change related to the trainings, which has been measured through qualitative and quantitative data collected by PSI and through the Mercy Corps Dashboard.

	Total	% Male	% Female
Mobilizers	804	61%	39%
Communicators	14719	56%	44%
Beneficiary reach as at March 31	2158288	51%	49%
Communities	3014		
Counties	15		
Lead-partners	26		
Sub-partners	51		
Total Partners (including IREX/PSI)	79		

Project Extension

Overview

The PSI/Liberia Facilitator Teams focused efforts during the April through June No-Cost Extension on both the National Measles and Polio Vaccination Campaign and capacity building of Mobilizers and Communicators. The initial work-plan for the extension focused exclusively around capacity building of Mobilizers and Communicators on Ebola messaging and safe practices, but this was adjusted in the second half of the extension due to requests from the Ministry of Health. As the Ebola outbreak was declining in severity and scope in Liberia, there was a significant spike in cases of measles as well as other diseases which have been neglected since the onset of the outbreak. The initial vaccination campaign was not well received by community members, since the timing coincided with the Ebola Vaccination trials. Given the low turnout during the initial round of vaccinations, the MoH requested to host an additional campaign and specifically wanted support from key players in the Ebola Social Mobilization Response in disseminating messages and promoting behavior change.

Vaccination Campaign

The PSI/Facilitators travelled to all fifteen counties in an effort to boost the Ministry of Health's Integrated Vaccination Campaign for children under five from April 21 until May 7, 2015. The intent of this exercise was to work with 28 partner organizations on the "Listen, Learn, Act" methodology as it relates to the vaccination campaign in order to increase E-CAP Communicators' knowledge of the campaign to ultimately increase parents' awareness of the vaccination campaign by. This helped to dispel fears surrounding the campaign, particularly among community members who believed the measles and polio vaccine would transmit Ebola to children. A village chief in Karpu's Town Sinoe County said "so this vaccine that will be given is not the Ebola vaccine? I already told my people not to go for the vaccine but with this information that you have brought to us, that the vaccine is for measles and the worm

medicine, I will be part of the people who will encourage the mothers to carry their children for the vaccine."

In total 862 communicators were visited over the three week time period, though a limited number of Mobilizes attended the sessions. Partner organizations were sometimes unaware of the schedule and said that they did not have adequate time to prepare for the sessions. This was likely due to the rushed nature of the campaign, given there was little turn-around time between the request from the Ministry of Health and the start of the sessions. However, the activity was still effective in reaching the communities as campaign materials created by UNICEF and the Social Mobilization Committee were disseminated through one-on-one sessions, as well as in large community events organized by communicators.

Participating Organizations and Locations of Vaccination Trainings

No.	Name Of Organization	Location
1	WANEP	Harper
2	RECIVE	Barclayville
3	WCI	Harper
4	RESPECT	Zwedru
5	PUSH	Sinoe
6	VOSEIDA	Sinoe
7	MRU-YP	Sinoe
8	RHRAP	Gbarpolu
9	MRYP	Gbarpolu
10	YAPA	Gbarpolu
11	WONGOSOL	Bomi/Montserrado
12	FCA/ SLPP	Cape Mount
13	CLA	Cape Mount
15	CHESS	Nimba
16	YMCA	Nimba
17	Concern Worldwide	Lofa/Grand Bassa
18	ZODWOCA	Lofa
19	YOTAN	Bong
20	PNO	Bong
21	Equip	Bong
22	CSI	Lofa
23	FAWE	Grand Bassa
24	Equip	Grand Bassa
25	PEP	Montserrado
26	SAIL	Montserrado/Margibi
27	WCI	Margibi/Grand Bassa
28	NMCL	Montserrado

Additional Extension Activities

In addition to the vaccination campaign activities, the E-CAP team spent three weeks of the extension focusing on capacity building of partners who needed additional technical assistance from the PSI/Liberia

Facilitators. PSI/Liberia and Mercy Corps decided which partners would be targeted during the capacity building portion for extension and created an adaptive, participatory field campaign. Two-person field teams selected specific regions of the country and worked with partners during a three-day field visit, focusing specifically on:

- Using additional teaching tools to promote Ebola awareness and the need for vigilance as Liberia transitions to zero cases;
- Fine-tuning messages disseminated during the initial round of trainings and adapting methodology so that it is understood by all partners;
- Promoting the need to detect and report suspects as a mean to risk reduction of future outbreaks; and/or
- Meeting with county health teams to ensure that partners are working closely together, to promote a restored health system.

Teams also worked with border surveillance teams when possible and ensured that there is a sustained effort to keep borders safe, by targeting communities and partner organizations working along the borders.

Monitoring and Evaluation

Overview

Under E-CAP PSI's chief responsibilities were to develop relevant Ebola health messages that aligned with MoHSW priorities, and to provide training to mobilizers identified by each partner NGO. These trainings took place on an ongoing basis in each county throughout the life of the project, facilitated by teams of PSI staff. The E-CAP methodology utilized a cascade model of message dissemination, requiring PSI trainers (Facilitators) to train Mobilizers from the various partners, who in turn trained community members identified as Communicators, who then educated the members of the community.

Given that there were many opportunities for the breakdown of messages to occur in this chain of communication, it was critical to ensure that all initial messages passed along from each PSI Facilitator were uniform and clearly articulated. It was also necessary to ensure that message dissemination continued at the community level long after the Mobilizers were trained, and that these messages remained relevant to community members. The PSI/Liberia M&E team was responsible for developing and executing activities to assess message fidelity down the cascade and relevance of these messages at the community level.

Key accomplishments of the PSI/Liberia M&E team:

- Assessed E-CAP message fidelity at all PSI trainings with the use of checklists, voice recordings, and post-training interviews with participants;
- Determined saliency of messages post-training by conducting follow-up telephone interviews with Mobilizers and Communicators;
- Conducted spot checks in the field with partner NGOs to learn how E-CAP messages translated to action and learn more about barriers to behavior change; and

- Conducted an intensive M&E activity with 12 E-CAP partners across 8 counties to better understand interpretation and application of E-CAP messages at the community level by assessing each level of the cascade model.

Methods and Tools:

PSI's M&E unit was responsible for routine monitoring of all master trainings conducted by PSI facilitators in an effort to assess E-CAP message fidelity. M&E staff would link up with PSI Facilitators at various training sites throughout the country and provide immediate feedback to the trainers based on observations of the training and use of an E-CAP checklist. This checklist outlined the key talking points for each of the E-CAP topic areas and components of the training that supported skill development, since strengthening of facilitation skills among Mobilizers was a critical component of the training. The checklist was programmed to tablets, which also allowed M&E staff to capture audio recordings of the training that would help gain more insight into participant experiences with Ebola in their communities. Immediately post-training, participants were randomly selected to participate in interviews to learn more about demographics, potential barriers and drivers to E-CAP work and main takeaways from the training itself. This information was then fed back into programming, allowing adjustments to be made on an as-needed basis.

Starting two weeks post-training, follow-up phone interviews were conducted with Mobilizers to monitor the saliency of the messages and identify any challenges Mobilizers were facing in their field work. Subsequently, Communicators were also called for follow-up interviews to cross-check the information received from the Mobilizers.

Spot checks were conducted in the field throughout the project using similar qualitative interview techniques and direct observations of Mobilizer and Communicator field work. This allowed the team to triangulate and determine gaps in self-reports from Mobilizers and Communicators compared to the execution of activities in the field.

A final M&E activity was the assessment of the interpretation and application of E-CAP messages at the community level following the initial rounds of trainings. A total of 12 partners across 8 counties participated, and each level of the cascade model were assessed. Tools were developed and administered to partner M&E staff, Mobilizers, Communicators, and community members. A mixed method, although heavily qualitative, approach was used. Briefs were drafted and shared with each partner, and results were used to inform the E-CAP refresher trainings.

Lessons Learned:

Overall, the reach of E-CAP, bolstered by the strategy of working with locally-based partner organizations made E-CAP an extremely effective program during the Ebola response. E-CAP provided locally active partner organizations with important information but also enabled them to adapt the project as they saw fit, often times working with the structures already in place through local NGOs or community groups. The structure of E-CAP also allowed for quick message dissemination through the cascade method of training coupled with the use cell phones and applications such as "U-Report." The lessons learned and challenges observed throughout E-CAP have been valuable in project design for future rounds of E-CAP and understanding what didn't work will better serve other social mobilization campaigns as well.

Lessons Learned and Challenges	Recommendations
<p>- The "Listen, Learn, Act" methodology was well received at the Facilitator trainings, but was often difficult to for the Mobilizers and Communicators to convey Ebola Messages using this type of teaching style to community members.</p> <p>The field visits with the communicators and mobilisers allowed facilitators to have a practical experience of the impact of the skills that was provided to the communicators. -The trainings were designed so that the PSI Facilitators rotated through partner organizations in 2 or 3 day trainings, which was necessary during the Ebola outbreak.</p> <p>-Allowing partners the autonomy to set up E-CAP according to their own organizational structure allowed for flexibility and ownership over the project. However, this often meant that there were differences in job roles with similar titles, pay, and amount of supervision provided in the field which lead to some partner organization staff working effectively as compare to the others.</p> <p>-Many partners, particularly in rural areas expressed a need for more health education materials or hands-on teaching tools. The project was designed so that it would work without tools, but for less skilled facilitators or illiterate groups, there was a need for practical materials.</p> <p>-Most of the data collection was done through smart-phones, while this is useful for quick data collection it also limited data collection to people who were literate and technologically equipped.</p> <p>-The project focused on all fifteen counties in Liberia and geographic area was not necessarily a criteria for partner selection.</p> <p>-The E-CAP project created a campaign using billboards to assist in the reduction of stigmatization in Liberia and to promote unity among Liberians. The survivors used in the photos were informed and signed consent forms, however after erecting the billboards one of the survivors wanted the billboards removed.</p>	<p>- This was a unique and highly inclusive Adult Participatory Learning Method which should be used in other trainings, but should be tailored to include a more direct methodology for community groups.</p> <p>-Allowing for longer field visits with each organization or having permanent staff based in each region would have a greater impact on long lasting behavior change</p> <p>-Future rounds of E-CAP should have more guidelines and protocols for project implementation so that the project is standardized; this will ensure that roles are more clearly defined and that monitoring is more specific.</p> <p>- This was adapted towards the end of the project, but the next round of E-CAP should also include a standard teaching tool catered towards illiterate groups in Liberia.</p> <p>- Allowing for various methods of data collection would ensure that the responses weren't limited to only those who have smart phones and know how to use them; partners could include village surveillance books held by CHVS.</p> <p>-In the future, all fifteen counties should still be included, but it is crucial to have a specific focus on outbreak areas and border regions.</p> <p>- Though there are currently other billboard campaigns using survivors, future recommendations would be to use survivor groups for campaigns. Additionally, there needs to be continued education against stigmatization of survivors.</p>

External Challenges:

The aim of the E-CAP project was to promote behavior change and support community mobilization in Liberia throughout the Ebola outbreak. However, lasting behavior change that will make a significant impact in the coming years in the fight against Ebola and other tropical diseases will take time.

Challenges that stem from both the disease itself and cultural norms in Liberia, will need to be continually addressed in social mobilization campaigns. Examples of these challenges include:

- Although Liberia was declared Ebola-free, there is still stigma against the disease to the extent that suspects will often not report or are more often to diagnose the illness as Malaria. Ebola may continue to be misdiagnosed as another tropical disease, not only because of stigma surrounding Ebola, but also because the symptoms presented are often similar to other diseases.
- Stigmatization of survivors and their family members continues to be a problem which should be addressed by social mobilization organizations and public health campaigns.
- The lasting economic impact of Ebola will require that the government and external organizations continue to provide support to livelihood building programs in Liberia.
- Porous borders between Liberia, Guinea, and Sierra Leone will enable Ebola to continue to spread through West Africa if suspects at the borders are not detected.
- Health systems and trust in the MoH was diminished during the outbreak because of poor response, inability to respond to the outbreak, and dishonesty pertaining to the severity of the outbreak in 2014.

Stories from the Field:

Though the data collected and various reports present a comprehensive view of the project, the stories from the field complete the picture of E-CAP and the 2014-2015 Ebola outbreak. Examples of these stories are included below (written in Liberian English):

Mobilizer's Story

1. *"My husband and my household was killed by Ebola. When they got sick with the virus, they were all taken to the ETU; but none survived. When I came down with the virus, I was not taken to the ETU. I received home treatment and then became the only survivor in my house. This made me to really believe that the ETU is an opened grave. I could not have been alive to see anyone closer to me be taken to the ETU. When I got well, I couldn't afford the trauma to stay in the house where the most precious people in my life mysteriously died before my eyes. So as a weeping widow and a suddenly childless mother; I went to my mother in Ganta, Nimba County to find comfort. In Ganta people did not talk badly to me, but they really avoided me. I felt finished. Later I got involved with the social mobilization job with Women Campaign International (WCI) on the Ebola Community Action Platform (E-CAP) project. At the first workshop with the PSI Facilitators, when I was informed that we are going to be promoting the ETU; I wanted to leave the job. But when we went through the content, my mind got revived and I felt like a heavy load has been offloaded from me. People who knew my story could not believe seeing me promoting the ETU afterward. On the other hand, through my work with communicators, people who were afraid of me started coming around me.*

The E-CAP work has not only put food on my table, it has importantly reintegrated me into the society. " JS-Nimba County

Communicator's Story

2. *"My brother died of Ebola in September 2014 at the Ebola Treatment Unit (ETU) in Monrovia after been transferred there!! Before his death, he called and told us that he was sure of dying not only due to Ebola but from hunger, limited attention and treatment.*

I trusted my brother as he did not one day tell me lies!!!

Since his death, my community and I know the ETU as a death sentence place. Due to this, we have resisted anyone who talks about the ETU.

About two weeks ago, I was clearly educated on the ETU by CHES mobilizer Yenpue Mahn after church service, sis Yenpue told me that at the ETU you eat 3 times a day, provided new phone, clothing, family visitation is allowed and conditions at all ETUs have improved, I have joined sis Yenpue as a communicator to spread the good news about the ETU because I trust her as a friend and don't want anybody suffering from Ebola again!!!" MT, Nimba

Community Dweller's story

3. *"My community has stopped every burial rite that we Muslims carry out when a relative dies. We don't touch a dead body any longer; we wait for the burial team. This is so painful as it is not our tradition but what to do? Our people are dying. Some of the communicators here from the E-CAP project say we should not touch dead body, we should wait for the burial team to bury our relatives. Imam, Cape Mount*

Conclusion:

The E-CAP project was unique because it focused specifically on local partner organizations, with the overall aim of building the capacity of these organizations to respond to the current outbreak as well as any future outbreaks. The partner organizations played a crucial role in the initial eradication of the disease and the approach of working with local partners, should be used in future social mobilization campaigns. Few other disease response campaigns engaged community-based organizations and local partner organizations, which is part of what made the E-CAP program successful. However as the country continues to completely eliminate Ebola and rebuild its health system, it will be necessary in the coming months to continually evaluate what worked throughout the project in order to build a better response in the future and in continued rounds of E-CAP.

E-CAP has been extremely successful both in terms of programmatic reach and behavior change related to Ebola. The use of local partner organizations to implement behavior change communication, was the major contributing factor to the success of the project. Many of our partners were able to reach communities in exceptional remote areas and the messages likely better received because Communicators were from these communities. The number of Communicators and communities reached was only possible because of a coordinated effort from the Ministry of Health, Mercy Corps, PSI/Liberia, and all partners.

Though the initial round of trainings were the foundation of the project, the refresher trainings provided continued and additional support to partners and also allowed PSI/Liberia to gain a greater understanding of the various strategies being employed at the community-level by partner organizations. Moving forward, PSI/Liberia hopes to ensure that every Communicator and community has a solid understanding of E-CAP messaging and positive behavior change continues, during this transitional time period.

Utilizing the strength of Liberian communities and social mobilization campaigns will continue to be the greatest deterrents against disease in Liberia. The E-CAP project and other campaigns focusing on capacity building of local organizations supported this process and complemented the medical relief provided in response to the outbreak in Liberia. However, the only way to prevent future outbreaks is to have a continued presence in rural communities across Liberia and to promote a strengthened health system including at the community level. The response from the communities in Liberia, the government of Liberia, and the international community was swift, as it needs to be in a response program, but lasting change will take time. In order to continue to strengthen community health structures and build a disease response program that limits the risks of future outbreaks in Liberia, the MoH and international partners will need to focus on community-based disease detection.